SANOVA
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Patient Personal Information

First:_____ MI:_____ Last: _____

Mailing Address: _____ Apt #: _____

Zip:_____ City:_____ State:_____

E-Mail: _____

Would you like access to our patient portal and newsletter via email? ❑ Yes ❑ No, I decline

*It is the policy of Sanova Dermatology to **not** share your contact or email info with any third parties.*

Preferred Language: ❑ English ❑ Spanish ❑ Other (specify):_____

SS#_____ DOB: _____DL#: _____

Cell#: _____Home#:_____ Work#: _____

Gender: ❑ Male ❑ Female

Primary Race: ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ Declined to Specify

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Ethnicity: ❑ not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown

Employment Status: ❑ Employed ❑ Disabled ❑ Retired ❑ Part-time ❑ Not Employed ❑ Student ❑ Unknown

Student Status: ❑ Full time ❑ Part Time ❑ Not a Student ❑ Unknown

School Name: _____

Emergency Contact

Name:_____ Relationship:_____ Phone: _____

Primary Care Physician

Doctor Name: _____ Did this Doctor Refer you to us? ❑ Yes ❑ No

Office Phone Number: _____ Office Fax Number: _____

Referral Source: ❑ Facebook ❑ Twitter ❑ Yelp ❑ Google+ ❑ Insurance List

❑ Other:_____

Thank you for choosing Sanova Dermatology!

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Patient Insurance Information

PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑ Same as above

Name: _____ Relationship: _____

Mailing Address: _____ Apt #: _____

Zip:_____ City:_____ State:_____

DOB: _____ Phone (Home): _____ (Cell): _____

PRIMARY MEDICAL INSURANCE

Insurance Company: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

Date of Birth **(*Required):** _____ SSN: ___ - ___ - ___

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other (specify): _____

SECONDARY MEDICAL INSURANCE

Insurance Company: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

Date of Birth **(*Required):** _____ SSN: ___ - ___ - ___

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other (specify): _____

The above information is accurate and complete to the best of my knowledge.

_____ Date: _____

Signature of Patient/Responsible Party Date Signed

Thank you for choosing Sanova Dermatology!

Acknowledgement of Receipt of Summary/Notice of Privacy Practices

***Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies*.**

_____**RECEIPT OF *NOTICE OF PRIVACY PRACTICES (HIPAA)***

I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records. This is also posted on Sanova Dermatology's website at sanovadermatology.com.

_____**CONTACT PERMISSION**

In the event that Sanova Dermatology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- ❑ Leave a message on an answering machine or voice mail. Phone # _____
- ❑ Speak with spouse/significant other. Name: _____
- ❑ Speak with other family members. Name: _____

_____**CONSENT TO TELEPHONE/EMAIL COMMUNICATION**

I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is **not** secure, **not** to be used for any emergent matters, and response will be given back within three to five business days.

_____**CONSENT TO TREATMENT**

I consent to the performance of those examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I authorize Sanova Dermatology to take photographs/videos of myself; I understand that the photograph/video will *only be used in my medical record and will not be released without my prior authorization*. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

Signature_____ **Date Signed**_____

Patient Printed Name/Legal Guardian _____

If Legal Guardian, please indicate relationship to the patient: ❑Parent ❑ Legal Guardian

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- ❑ Individual waived signature
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other:_____

_____ _____

Practice Representative Date

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Financial Policy

Thank you for choosing Sanova Dermatology! We are committed to the success of your medical treatment and care.
Please understand that payment of your bill is part of this treatment and care.
Please initial next to each paragraph as well as sign at the bottom of this page

_____**Insurance-Claims.** If we participate with your managed care or commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected
- We obtain a denial from your insurance company
- We have not received payment from the insurance within 60 days of our filing the claim

Please be advised that anything you choose to have removed, biopsied, or injected may not be covered under your office co-pay and might be excluded from coverage or subject to your deductible. We will make every effort to contact your insurance company to verify your benefits, but in the event we are unable to reach them, you will be responsible at the time of service for your co-payment as well as payment for procedures performed. Such procedures include but are not limited to biopsies, injections, removal of warts, moles, pre-cancers, skin cancers, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning or application of a blistering agent.

_____**Authorization/Financial Responsibility**. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Sanova Dermatology, PLLC for services rendered to me.

_____**Medicare**. We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability in the event a service is provided that is not covered by Medicare.

_____ **Patients-Without-Insurance-Coverage-or-Out-of-Network-Coverage**. Payment is due for all services on the day they are rendered.

_____ **Returned Checks**. There will be a $25.00 service fee charged to your account if your check is returned for any reason. Upon notification from our office, payment of the entire balance is due immediately.

_____ **Skin Care products**. If you purchase skin care products/supplies from our office, please understand that these items are a non-refundable. If the product/supply is defective, we will gladly replace the item(s).

_____ **No Show Policy**. We kindly request that you give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan. Cosmetic appointments canceled without a 24 hour notice may result in the loss of your $100.00 deposit.
If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and policies listed above, your responsibility regarding charges incurred in this office, and have read and reviewed all of the above notices.

Signature _____ Date _____

Thank you for choosing Sanova Dermatology!

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ATTENTION SANOVA PATIENTS:
YOU MAY RECEIVE A BILL FROM A LABORATORY

If your provider performs a biopsy or lab test during your appointment, it will be sent to an outside laboratory to be examined by a pathologist. The pathologist will communicate your lab results to your provider via a pathology report. Laboratory examinations are performed when more information on your skin condition is needed to ensure your condition is properly treated.

The outside laboratory will submit a bill to your insurance company. **You may receive a bill from them should you have deductibles, coinsurance, or copayments.** If you're a self-pay patient, rates will be discussed with you during your visit.

If you have any questions regarding this process, please do not hesitate to ask your physician during your exam.

By signing below, you understand that you may be billed by an outside laboratory in the event that you receive a biopsy or lab test during your examination.

Signature _____ Date _____

Thank you for choosing Sanova Dermatology!

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Patient Medical History

Name_____ Date _____

Referring Physician_____ Primary Care Physician_____ Date of Birth___ / ___/ _____

Reason for visit?_____ Best phone # to reach you to discuss results?_____ Okay to leave a message? Y N

Preferred Pharmacy (Include Location)_____ Occupation:_____

❑Yes ❑No Do you drink alcohol? If yes, how many drinks per day?_____

❑Yes ❑No Do you smoke? If yes, how many packs per day?_____

❑Yes ❑No Do you use illegal street drugs? If yes, list _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

❑Yes❑ No Anxiety
❑Yes ❑No Artificial Joints
❑Yes ❑No Asthma
❑Yes ❑No Atrial Fibrillation
❑Yes ❑No Cancer (non-skin)
❑Yes ❑No COPD
❑Yes ❑No Coronary Artery Disease
❑Yes ❑No Depression
❑Yes ❑No End Stage Renal Disease
❑Yes❑ No Hearing Loss
❑Yes ❑No Hepatitis
❑Yes ❑No High Blood Pressure
❑Yes ❑No HIV/AIDS
❑Yes ❑No High Cholesterol
❑Yes ❑No Seasonal Allergies
❑Yes ❑No Seizures
❑Yes ❑No Thyroid Disease
❑Yes ❑No Valve Replacement

Other _____

SKIN DISEASE HISTORY

Please check all that apply

❑Yes ❑No Actinic Keratosis
❑Yes ❑No Basal Cell Skin Cancer
❑Yes ❑No Melanoma (malignant)
❑Yes ❑No Squamous Cell Skin Cancer
❑Yes ❑No Precancerous Moles
❑Yes ❑No (Atypical/Dysplastic)
❑Yes ❑No History of bad or blistering sunburns?
If yes, what SPF?_____
❑Yes ❑No Do you have a family history of Melanoma?
If yes, who?_____

REVIEW OF SYMPTOMS

Are you currently experiencing and of the following?

❑Yes ❑No Runny Nose/Itchy Eyes
❑Yes ❑No Palpitations/Chest Pain
❑Yes ❑No Leg Swelling
❑Yes ❑No Fever/Chills
❑Yes ❑No Unplanned Weight Loss
❑Yes ❑No Cold/Heat Intolerance
❑Yes ❑No Excessive Thirst/Hunger
❑Yes ❑No Swallowing Problems
❑Yes ❑No Mouth or Cold Sores
❑Yes ❑No Nausea/Vomiting
❑Yes ❑No Diarrhea/ Constipation
❑Yes ❑No Burning with Urination
❑Yes ❑No Blood in Urine
❑Yes ❑No Enlarged Glands/Lymph Nodes
❑Yes ❑No Joint Pains
❑Yes ❑No Muscle Aches
❑Yes ❑No Headaches
❑Yes ❑No Memory Loss
❑Yes ❑No Depression
❑Yes ❑No Anxiety
❑Yes ❑No Wheezing/Asthma
❑Yes ❑No Shortness of Breath
❑Yes ❑No Suppressed Immune System
❑Yes ❑No Rash with Medication or Foods
❑Yes ❑No Problems Healing
❑Yes ❑No Scars/Keloids After Surgery

❑Yes ❑No Do you have immediate family with a history of Skin Disease?
If yes, who/type?_____
❑Yes ❑No Do you have immediate family with a history of Skin Cancer?
If yes, who/type?_____

PAST SURGICAL HISTORY

Please list previous surgical procedures.

_____
_____
_____
_____
_____
_____

ALLERGIES

Please list all allergies and reactions

_____
_____

MEDICATIONS

Please list all current medications (OTC, Herbal, Etc.)

_____
_____
_____
_____

ALERTS

Are you currently experiencing any of the following?

❑Yes ❑No Allergy to Latex or Tape
❑Yes ❑No Artificial Heart Valve
❑Yes ❑No Blood Thinner Use/Daily Aspirin
❑Yes ❑No Medication Prior to Procedures
❑Yes ❑No MRSA (Resistant Staph)
❑Yes ❑No Allergy to Lidocaine
❑Yes ❑No Artificial Joint in Past 2 Months
❑Yes ❑No Defibrillator
❑Yes ❑No Rapid heart Rate w/ Epinephrine
❑Yes ❑No Allergy to Topical Antibiotic
❑Yes ❑No Accutane Used in Past 6 Months
❑Yes ❑No Pacemaker
❑Yes ❑No Pregnant/Breastfeeding

EDUCATE YOURSELF Our physicians are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by checking all areas that interest you:

❑ Botox
❑ Cosmetic Fillers
❑ Non-Surgical Nose Job
❑ Lip Enhancement
❑ Underarm Odor/Sweating
❑ Eyelid Rejuvenation
❑ Eyelash Rejuvenation
❑ Neck Rejuvenation
❑ Neck/Chin Tightening
❑ Sensitivity to Deodorant
❑ Chemical Peels
❑ Acne Scarring
❑ Laser Hair Removal
❑ Spider Vein Treatment
❑ Double Chin Treatment
❑ Facial Redness
❑ Sun Spots
❑ Sculptra Butt Lift
❑ Skin Care Advice
❑ Tattoo Removal

Patient/Guardian Signature: _____ Date:_____

Thank you for choosing Sanova Dermatology!

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Patient Name:_____Date of Birth: _____

In accordance with the Federal Health Policy, please answer the following questions:

1) **Flu – Asked at every eligible visit**

- During the most recent flu season, did you receive a flu vaccination? Yes / No

  i) If no, why not? _____

2) **Tobacco – Asked 1 time per year**

- Do you use tobacco products? Yes / Formerly / Never

3) **Pneumonia (for patients 65+) – Asked 1 time per year**

- Have you EVER received a pneumonia vaccination? Yes / No
- If yes, what year? _____

4) **Do you have a surrogate decision maker (for patients 65+)? – Asked 1 time per year** Yes / No

- If yes, enter their information:

  Name: _____

  Phone Number: _____

Signature:_____ Date:_____

Your Medical Patient Portal

Sanova Dermatology's Medical Patient Portal is designed to work for you. Using the Portal, you can view your records, enter medical information, and send messages to your provider. *Missed our call?* Don't play phone tag with our nurses. **All biopsy and lab results will be published on the patient portal within 7-10 days of your office visit**. *Need a refill?* **All prescription refill requests can be submitted directly through the Portal.**

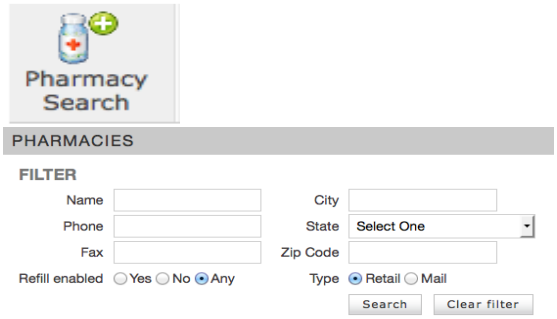
Logging On

1. Type the URL below into your browser window. **DO NOT** type *www* or *https* in front of the URL.
   sanovaderm.ema.md
2. Log in with your username and password
3. First time? A link will be emailed to you at the time of your first patient visit. You will receive an email with instructions on how to set your own password. The email link will expire in 24 hours. If the link has expired, you can use the "forgot password" link on the login page. If you do not have a username or password, please contact us at (512) 837-3376.

Utilizing the Patient Portal

Through the Portal, patients can view and modify their medications, allergies, pharmacy, past medical history, skin disease history, social history, and family history.

- For example, to add a pharmacy, select *Pharmacy Search*.
- Enter as much criteria as possible and click "Search." Click the blue link to add the pharmacy.



Your contact information and insurance information can be viewed; however you must contact the clinic by phone to make changes or corrections.

Your Visit Info

Patients can view their *visit notes*, *educational handouts*, and any *test results* the provider has posted.

My Health

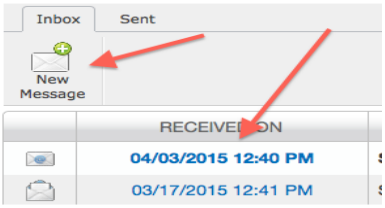
- To view records, select the date in blue pertaining to the visit you'd like to view under "Visit Date."
- To view the Education Handout of that visit, select the "Patient Education" link after clicking on the Visit Note.

Tests and Results

- Select the date in BLUE to view the pathology report.
- Select the blue information bubble to the right of the result, to view more information on this diagnosis.
- Select *Compose* to generate an Intramail to your provider.

Contact Us

Need a refill? Have a question only your doctor can answer? Patients can send messages to their provider and receive messages from their providers.



- Select the date in blue to view the Intramail.
- Select *New Message* to generate a new Intramail to your provider

Thank you for choosing Sanova Dermatology!

CANCELLATION/ NO SHOW/ DEPOSIT POLICY

Same day cancellations and no-shows do not only impact us, but also impact other patients who are needing to schedule. Due to limited availability and high demand of appointments, we would like to remind you of our scheduling policies.

Medical Appointments:

- A $35.00 fee will be charged to your account for any changes or cancellations made to your appointment without a 24 hour notice.

Cosmetic Appointments:

- A $100.00 deposit is **REQUIRED** for all cosmetic appointments/consultations and must be collected at the time of scheduling.
- Changes or cancellations made to your cosmetic appointment without a 24 hour notice will result in the loss of your deposit.
- Changes or cancellations made to your cosmetic appointment with a 24 hour notice or more will allow your deposit to roll over and be kept on your account.
- Your deposit can be applied to your cosmetic visit or kept on your account for your next cosmetic visit if scheduled at the time of checkout.
- Miradry appointments require a $200.00 deposit that will be applied to your procedure or forfeited due to same day cancellation or no show.

Subcision, Blepharoplasty, Sclerotherapy, TCA Cross, and Non-surgical Butt Lift appointments **REQUIRE** a cosmetic consultation prior to treatment. A $100.00 consultation fee will be collected at the time of scheduling and will **NOT** be applied to the treatment. Treatment will be scheduled after your consultation and a $100.00 deposit is required to schedule. This deposit will be applied towards your treatment or forfeited due to cancellation or changes made to your appointment without a 24 hour notice.

All Appointments:

- A 15 minute grace period is allowed for patients running behind their scheduled time. Any patients arriving 15 minutes after their scheduled appointment time may be asked to reschedule their appointment. If you are running behind, please call our office and let a staff member know what time you plan to arrive.

By scheduling your appointment and/or paying your deposit, you are agreeing that you understand and accept these policies.

We thank you for your understanding in our effort to provide excellent patient care to all of our valued patients!